Healthy Back Chiropractic

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Personal Injury Accident Information

Patient Name _____ Date of Birth _____

Is this visit related to an auto accident? □ Yes □ No Date of the accident _____

Were you the at fault driver? Yes No

Your Insurance

Who is your Insurance Company? _____

Do you have med-pay or PIP (personal injury protection)? Yes No

Claim Number: _____

Adjuster: _____ Phone #: _____

Attorney Information

Do you have an Attorney? Yes No

Attorney Name: _____ Phone #: _____

Please describe in detail the accident. _____

_____

_____

_____

_____

Please answer the following questions only if you were injured in an automobile accident:

1. Were you the: □ driver □ the passenger □ a pedestrian □ on a bicycle □ on a motorcycle

2. Were you: □ hit (by another vehicle) or □ at fault (you caused the accident)

3. From which side were you struck: □ behind □ the front □ the right side □ the left side
□ the right front □ the left front □ the right back □ the left back

4. At the time of impact were you: □ stopped □ moving □ walking □ standing still □ running
□ bicycling □ riding a motorcycle □ crossing the street

5. Were you moving at the time of the accident? □ Yes □ No If yes, what was your speed? _____

Acct # _____

6. Was the involved party moving when the accident occurred? □ Yes □ No

If yes, what was their speed? _____

7. Did you have your seat belt on at the time of the accident? □ Yes □ No

8. Was your head turned at the time of the accident? □ Yes □ No If yes, were you looking:

□ Forward □ looking to the right □ looking to the left □ looking behind you □ looking up
□ looking down

9. Were you alone at the time of the accident? □ Yes □ No If no, who was with you? _____

10. What parts of your body hit other structures at the time of impact? (check all that apply)

□ Head □Face □ Forehead □ Back of head □ Right TMJ □ Left TMJ □ Right Shoulder
□ Left Shoulder □ Right Arm □ Left Arm □ Right Elbow □ Left Elbow □ Right Wrist
□ Left Wrist □ Right Hand □ Left Hand □ Right Leg □ Right Knee □ Left Knee
□ Right Ankle □ Left Ankle □ Right Foot □ Left Foot

11. What structures did you hit? (check all that apply)

□ Steering Wheel □ Windshield □ Side Window □ Door □ Roof □ Dashboard □ Headrest
□ Seat □ Floor □ Side of Car □ Hood of Car □ Bumper □ Trunk □ The Pavement □ Tree
□ Another Car □ Another Person □ Another Object □ A Wall

12. How did you feel after the collision? (check all that apply)

□ Stunned □ Disoriented □ Lost Consciousness □ Tightness □ Felt Mild Discomfort
□ Felt Moderate Discomfort □ Felt Severe Discomfort □ Felt Intense Pain □ Frightened
□ Felt a Popping and Ripping Sensation □ Went to Hospital

13. Who was cited for the accident? □ Me □ Other Driver

14. Have you had one or more of the following symptoms since your accident?

□ Cannot sleep due to the accident □ having trouble getting to sleep since the accident
□ Lost time from work due to the accident □ Have been depressed since the accident occurred

15. Have you been treated for injuries related to the accident already? □ Yes □ No

If yes, by whom? _____

Did they perform any diagnostic testing? □ Yes □ No

16. Have you lost wages or not been able to work due to the accident? □ Yes □ No

Acct # _____